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22 May 2010

Under pressure

Salary Survey reveals the cost of rising workloads page 4

CPD ZONE

When neuropathic pain makes diabetes hard to bear

LYRICA® PREGABALIN

Fast onset. Sustained relief.

- Proven clinical efficacy in neuropathic pain[1-4]
- Rapid[2,4] and sustained relief in patients with painful diabetic peripheral neuropathy[2,4,5]
- Well-tolerated with a predictable pharmacokinetic profile[6]

Lyrica® ▼ (pregabalin) Prescribing Information
Refer to Summary of Product Characteristics (SmPC) before prescribing. Presentation: Lyrica is supplied in hard capsules containing 25mg, 50mg, 75mg, 100mg, 150mg, 200mg or 300mg of pregabalin. **Indications:** Treatment of peripheral and central neuropathic pain in adults. **Dosage:** *Adults* 150 to 600mg per day in either two or three divided doses taken orally. Treatment may be initiated at a dose of 150mg per day and, based on individual patient response and tolerability, may be increased to 300mg per day after an interval of 3-7 days, and to a maximum dose of 600mg per day after an additional 7 day interval. Treatment should be discontinued gradually over a minimum of one week. *Renal impairment/ Haemodialysis:* dosage adjustment necessary, see SmPC. *Hepatic impairment:* No dosage adjustment required. *Elderly:* Dosage adjustment required if impaired renal function. *Children and adolescents:* Not recommended. **Contra-indications:** Hypersensitivity to active substance or excipients. **Warnings and precautions:** There have been reports of hypersensitivity reactions, including cases of angioedema. Pregabalin should be discontinued immediately if symptoms of angioedema, such as facial, perioral, or upper airway swelling occur. Patients with galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take Lyrica. Some diabetic patients who gain weight may require adjustment to hypoglycaemic medication. Occurrence of dizziness and somnolence could increase accidental injury (fall) in elderly patients. There have also been post-marketing reports of loss of consciousness, confusion or mental impairment. Cases of renal failure have been reported and discontinuation of pregabalin did show reversibility of this adverse effect. In controlled studies, a higher proportion of patients treated with pregabalin reported blurred vision than did patients treated with placebo who resolved in a majority of cases with continued dosing. In the clinical studies where ophthalmologic testing was conducted, the incidence of visual acuity reduction and visual field changes was greater in pregabalin-treated patients than in placebo-treated patients, the incidence of fundoscopic changes was greater in placebo treated patients. In the postmarketing experience, visual adverse reactions have also been reported, most of which refer to transient vision loss, visual blurring or other changes of visual acuity. Discontinuation of pregabalin may result in resolution or improvement of these visual symptoms. Suicidal ideation and behaviour have been reported in patients treated with anti-epileptic agents. A meta-analysis of randomised placebo controlled trials of anti-epileptic drugs has also shown a small increased risk of suicidal ideation and behaviour. The data does not exclude the possibility of an increased risk for pregabalin. Patients should be monitored for signs of suicidal ideation and behaviours and appropriate treatment should be considered. Patients (and caregivers of patients) should be advised to seek medical advice should signs of suicidal ideation or behaviour emerge. After discontinuation of short and long-term treatment withdrawal symptoms have been observed in some patients, insomnia, headache, nausea, diarrhoea, flu syndrome, nervousness, depression, pain, sweating and dizziness. The patient should be informed about this at the start of the treatment. Concerning discontinuation of long-term treatment there are no data of the incidence and severity of withdrawal symptoms in relation to duration of use and dosage of pregabalin (see side effects). There have been post-marketing reports of congestive heart failure in some patients receiving pregabalin. These were mostly elderly, cardiovascular compromised patients who received treatment for a neuropathic indication. Pregabalin should be used with caution in these patients. Discontinuation of pregabalin may resolve the reaction. **Ability to drive and use machines:** May affect ability to drive or operate machinery. **Interactions:** Pregabalin appears to be additive in the impairment of cognitive and gross motor function caused by oxycodone and may potentiate the effects of ethanol and lorazepam. In the postmarketing experience, there are reports of respiratory failure and coma in patients taking pregabalin and other CNS depressant medications. **Pregnancy and lactation:** Lyrica should not be used during pregnancy unless benefit outweighs risk. Effective contraception must be used in women of childbearing potential. Breast-feeding is not recommended during treatment with Lyrica. **Side effects:** Adverse reactions during clinical trials were usually mild to moderate. Most commonly (>1/10) reported side effects in placebo-controlled, double-blind studies were somnolence and dizziness. Commonly (>1/100, <1/10) reported side effects were appetite increased, euphoric mood, confusion, libido decreased, irritability, ataxia, disturbance in attention, coordination abnormal, memory impairment, tremor, dysarthria, paraesthesia, vision blurred, diplopia, disorientation, balance disorder, insomnia, vertigo, dry mouth, constipation, vomiting, flatulence, erectile dysfunction, fatigue, oedema peripheral, feeling drunk, lethargy, sedation, oedema, gait abnormal and weight increased. See SmPC for less commonly reported side effects. After discontinuation of short and long-term treatment withdrawal symptoms have been observed in some patients, insomnia, headache, nausea, diarrhoea, flu syndrome, nervousness, depression, pain, sweating and dizziness. Concerning discontinuation of long-term treatment there are no data of the incidence and severity of withdrawal symptoms in relation to duration of use and dosage of pregabalin (see warnings and precautions). In the post-marketing experience, the most commonly reported adverse events observed when pregabalin was taken in overdose included somnolence, confusional state, agitation, and restlessness. **Legal category:** POM. **Date of revision:** August 2009. **Package quantities, marketing authorisation numbers and basic NHS price:** Lyrica 25mg, EU/1/04/279/003, 56 caps £64.40, EU/1/04/279/004, 84 caps £96.60; Lyrica 50mg, EU/1/04/279/009, 84 caps £96.60; Lyrica 75mg, EU/1/04/279/012, 56 caps £64.40; Lyrica 100mg, EU/1/04/279/015, 84 caps £96.60, Lyrica 150mg, EU/1/04/279/018, 56 caps. £64.40, Lyrica 200mg, EU/1/04/279/021, 84 caps £96.60; Lyrica 300mg, EU/1/04/279/024, 56 caps £64.40. **Marketing Authorisation Holder:** Pfizer Limited, Ramsgate Road, Sandwich, Kent, CT13 9NJ, UK. Lyrica is a registered trade mark. **Further information is available on request from:** Medical Information Department, Pfizer Limited, Walton Oaks, Dorking Road, Walton-on-the-Hill, Surrey KT20 7NS.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Pfizer Medical Information on 01304 616161

References: 1. Siddall PJ, et al. Neurology 2006;67(10):1792-800. **2.** Freynhagen R, et al. Pain 2005;115(3):254-63. **3.** Freynhagen R, et al. Schmerz 2006;20(4):285-92. **4.** Freeman R, et al. Diabetes Care 2008;31(7):1448-54. **5.** Stacey BR, et al. Pain Med 2008;9(8):1202-8. **6.** LYRICA®, Summary of Product Characteristics (EMEA).

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> IT SOUNDS MORE LIKE A TARANTINO MOVIE THAN WHAT PASSES FOR LIFE IN AN AVERAGE DISPENSARY

Being attacked by knives, air rifles and guns or having bicycles and tills thrown at us is something we are more likely to associate with a Tarantino movie than a description of what passes for life in an average dispensary (p4).

But as the final part of our Salary Survey coverage reveals this week, these are just some of the unacceptable horrors a few unlucky pharmacists and their staff have experienced in the past year. One respondent told us that he considered it a good week if he hadn't called the police, and added he "hadn't had a machete attack outside the store in a while".

And if it weren't enough that a third of pharmacists told us they had been a victim of or witnessed a crime at work last year, there are also the reported levels of stress, intimidation and bullying that some grassroots pharmacists have to contend with.

While we accept those unhappy with their work environment are more likely to complain in surveys, we shouldn't dismiss the latest findings. Over 2,000 pharmacists and staff responded to this year's Salary Survey and the views are not dissimilar to previous results.

And neither can we say that employers have been shirking their responsibilities. The three biggest chains – Boots, Lloydspharmacy and the Co-operative Pharmacy – have been proactive in finding ways to help their staff cope and have implemented a range of employee support programmes, including cluster managers, change coaches, support networks and anonymous feedback mechanisms, for example.

But there's no doubt that the combination of relentless increases in workloads, customer demands, and contractual bureaucracy is creating an unrealistic burden. And if you add in the budget cuts that the new Lib-Con government has demanded from the NHS, it's clear it will get worse before it gets better.

The RPSGB has been the most vocal in finding a solution with the high profile Workplace Pressure campaign launched by its president Steve Churton in January last year. Since then we've had a symposium, a report on professional workloads and Council has issued a "strong" recommendation that employers ensure pharmacists take staff breaks.

It's absolutely a step in the right direction, but frankly it's not enough. Pharmacy practice is a world apart from a decade ago when the average pharmacy dispensed 3,000 items per month, and did the odd needle-exchange. Yet as we prepare for a contractual overhaul with the prospect of more services being delivered from pharmacy, little has changed in the way dispensaries operate. And to meet the future challenges, the sector needs to make some tough decisions. Some are already experimenting with innovative hub and spoke models or increasing automation, but the development is ad hoc.

There is a new professional leadership body in town and it needs to make this issue a priority.

Gary Paragpuri, Editor

CPD Zone

Cover: Getty Images (adapted)

Stress 'affecting patient services'

Dispensing safety and MUR quality suffering under strain, Salary Survey finds

Jennifer Richardson
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Workplace pressures on community pharmacists are affecting their abilities to deliver patient services, the 2010 C+D and PDA Union Salary Survey has found.

Hundreds of employed and locum pharmacists reported work-related issues including stress, depression, bullying, pressure from management and trouble sleeping.

And around a third of those who suffered from such problems believed it had affected the service they provided to patients.

Eighty five per cent of employed pharmacists responding to the Salary Survey said they had experienced stress in the past year, a similar proportion to that in last year's survey. But reported levels of other issues have increased. This year, 71 per cent of employed pharmacists said they had experienced pressure from management, compared to 56 per cent in 2008-09. And 51 per cent reported trouble sleeping, up from 39 per cent in last year's survey.

Locums apparently experienced less stress than employees in 2009-10, with 62 per cent reporting the issue. And about 4 per cent of both locums and employed pharmacists said they had experienced suicidal thoughts in the past year, again a similar figure to 2008-09.

By comparison, a 2009 survey by the Health and Safety Executive suggested that around 17 per cent of working individuals believed their job was very or extremely stressful. And around 2 to 3 per cent of the overall population are estimated to experience suicidal thoughts.

Several Salary Survey respondents took the time to describe the impact they believed workplace pressures had on patient service, including increased dispensing errors and near misses and poor quality MURs.

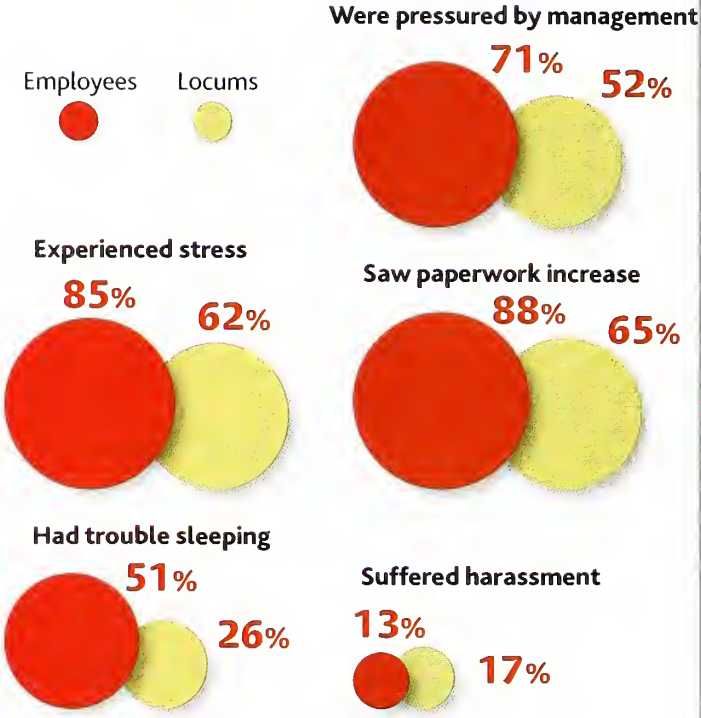
And one commented: "I'm probably less inclined to be proactive in trying to find ways to help patients as I'm too busy and stressed trying to hold everything else together and get the figures my employer wants."

This impact on patient safety was "very worrying", warned PDA director John Murphy. He added: "Yes, we have got a duty of care to our patients but we also have a duty of care to the people who work in pharmacies and the stats show you can't separate the two issues."

Pharmacists did want to carry out MURs and enhanced services, Mr Murphy added, but were finding it difficult with insufficient resources. The sector needed to address staffing levels through self-management and regulation, he said.

However, CCA chief executive Rob Darracott said: "CCA member companies have invested heavily in skill mix to free up pharmacists' time for MURs and other roles."

HOW PHARMACISTS FARED IN 2009-10

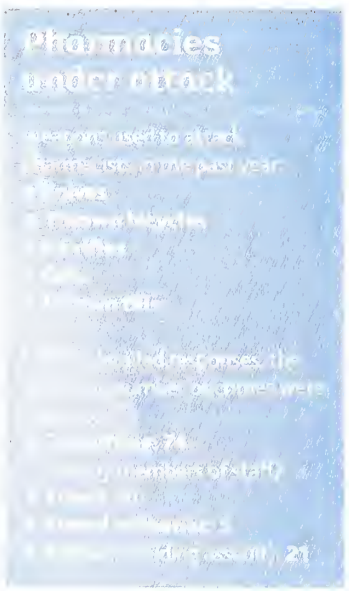


How pharmacy measures up on stress

- In 2008-09 an estimated 415,000 individuals in Britain who had worked in the previous year believed they were experiencing work-related stress at a level that was making them ill.
- Around 17 per cent of working individuals believe their job is very or extremely stressful.
- Self-reported work-related stress accounted for an estimated 11.4 million lost working days in Britain in 2008-09.

Source: Health and Safety Executive

One in three victim of crime



Almost one in three pharmacists has been either a victim of or a witness to crime at work, the C+D and PDA Union Salary Survey has revealed.

For the second year in a row, crime figures stand at around 28 per cent of employed pharmacists, with 144 of the 521 respondents having been hit by criminals.

PDA director John Murphy said the figures were "appalling", and called on the Department of Health to take action to shield pharmacy staff from violence.

He said: "The government ought to apply similar rigors to services like pharmacy and provide some protection, as they do in NHS properties."

It is every employer's responsibility to ensure the safety of staff, and employees should report all crime, including abuse and harassment, Mr Murphy added.

Common crimes mentioned by respondents ranged from shoplifting and theft to vandalism and prescription fraud.

Knife crime was also frequently reported, with several pharmacists reporting being held up at gun point. One respondent was shot at with an air rifle, smashing the pharmacy's windows, while another was forced to contact child protection services.

One respondent said he considered it a good week if he didn't call the police because of shoplifting. "Still, I haven't had a machete attack outside the store in a while," he added. **CC**

Salary Survey stats

85%
of employed pharmacists reported stress

15%
of stressed pharmacists felt supported by employers

28%
of pharmacists victims of crime

34%
of employed pharmacists feel less secure in their job this year

Employees lack support

Majority believe employers not providing help for workplace problems

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The majority of pharmacists believe their employers do not provide them with support for workplace problems such as stress, depression, poor motivation, bullying, pressure from management and intimidation from colleagues.

And more than a third of employee pharmacists told the 2010 C+D and PDA Union Salary Survey they felt they had not been given enough support to deal with the responsible pharmacist legislation, which came into force last October.

However, Boots, Lloydspharmacy and the Co-operative Pharmacy cited a range of support mechanisms they had implemented to support staff, including cluster managers, change coaches, support networks and anonymous feedback mechanisms. (For more on how employers are supporting staff, see www.chemistanddruggist.co.uk/salarysurvey)

Overall, 85 per cent of employees who reported stress and other workplace issues said that their employer did not provide support. The level of perceived help was even lower for locums, with just 7 per cent reporting that their contractors offered support.

Individual survey respondents painted a mixed picture of employer support across community pharmacy. Some employees of both small and large contractors praised the help they had received. But while several respondents said they had not asked for help, others felt they had reached out and been ignored.

English Pharmacy Board chair Lindsey Gilpin called on employers to address the issues raised by the survey. "We need to support pharmacists through the tough times," she said. "The exciting future that is beckoning will come to nothing if their workload and stress can't be managed in a better way."

A Department of Health report published in March highlighted those responsible for managing the health of health professionals, including the individuals, colleagues, employers and national bodies. Individuals must seek advice promptly, it said, but added: "[Employers] have a duty of care to their staff to ensure they work in a healthy environment and have the appropriate support and opportunities to enable them to maintain their health, wellbeing and safety."

An NPA spokesperson said: "Community pharmacy employers generally understand the importance of engaging and motivating staff and they go to considerable lengths to create the right conditions for safe practice and a good working environment overall."

Job security fears grow

Lack of job security remains a major worry for pharmacists, the C+D and PDA Salary Survey 2010 has found.

Over one third of respondents said they felt either a little less or a lot less secure in their jobs than they had last year.

Employees at independent pharmacies felt they had the least job security, with 12 per cent reporting they felt under threat of redundancy.

Nine per cent of pharmacists working for large chains had feared for their jobs.

Locum pharmacists were also hard hit, with 41 per cent reporting they had worried about lack of work in the past year.

One locum respondent to the Salary Survey said: "There are too many pharmacists now and still a lot of economic migrants. These factors increase the supply of locums.

"Pharmacists and pharmacies are being more conservative with taking on locums, in my experience."

An NPA spokesperson said erratic community pharmacy funding could feed uncertainty about investment in premises and staff. "Pharmacy needs sustained public investment and predictable cashflow." **HF**

Men, women and stress

The stress levels felt by men and women in pharmacy are roughly the same, but they seem to deal with the pressures differently, the Salary Survey has suggested. Eighty seven per cent of women and eighty five per cent of men reported that they had been stressed in the last year, but men were more likely to be drinking more than usual and also more likely to call in sick because they couldn't face work. The survey also revealed small differences in the amount of holiday taken by men versus women, and showed women to be far more supportive of the RPSGB's Workplace Pressure campaign. **ZS**

Women		Men
87%	Stressed	85%
11%	Drinking more	20%
7%	Called in sick because they couldn't face work	10%
89%	Took full holiday allowance	84%
35%	Back Society's Workplace Pressures campaign	16%

Paperwork blues

When it came to paperwork last year, employees bore the brunt of the burden, with 83 per cent responding to the Salary Survey seeing an increase last year. Locums fared a little better as only 65 per cent had seen a rise in paperwork, and some lucky individuals reported that paperwork had decreased "a lot".

Chain reaction

When it comes to management pressure, size really does matter. The proportion of employed pharmacists reporting pressure from management in the Salary Survey increased steadily with the size of the chain they worked for. Thirty-nine per cent of pharmacists who worked for single-pharmacy contractors reported the issue, compared to 52 per cent of those working for chains with up to 100 pharmacies and 83 per cent of those working for the largest companies.

Workplace pressures

The RPSGB's Workplace Pressure campaign to ease the strain on the sector proved less than popular with Salary Survey respondents. Less than 1 per cent said they thought it had been very successful, with almost three quarters billing it as "not at all" successful. See page 10 for more analysis on the campaign.

Headhunting

Despite worries about job security and the national employment picture looking bleak, two thirds of employee pharmacists responding to the Salary Survey said they had been headhunted by another company.

Holiday time

Fourteen per cent of employed pharmacists didn't take their full holiday allowance last year.

Where in the UK are pharmacists most likely to experience stress or be hit by crime?

See p26 for more details

In brief

GPhC fees

The GPhC was due to discuss registration fees for pharmacists for 2011 as C+D went to press. The proposed fee to remain on the register was £262 for pharmacists and £142 for pharmacy technicians.

Elizabeth Lee to appeal

Locum Elizabeth Lee is set to appeal her criminal conviction and sentence at the Royal Courts of Justice on Wednesday May 26. Ms Lee was handed a three-month suspended sentence for a single dispensing error last year.

DH ministers

Simon Burns MP, a Conservative, and Paul Burstow MP, a Liberal Democrat, have been appointed as ministers of state for health. Anne Milton MP and Earl Howe are junior ministers. It had not been decided who would be responsible for pharmacy as C+D went to press.

RPSGB pay rise

The RPSGB Council was due to agree a pay rise for staff on May 19. The proposed pay rise was around 2 to 3 per cent for well performing staff, with a performance-related increase of up to 5 per cent.

Novartis changes

Pharmacists will be required to order 10 products direct through the Novartis Patient Priority Supply Service from June 1 as the manufacturer streamlines its supply chain. Novartis said it would have "minimal impact", but the change follows criticism of some of its distribution arrangements by community pharmacists.

Lloyds mole screening

Lloydspharmacy will offer a free mole screening clinic in its Selfridges store on May 24. The two-hour clinic will involve consultations with a dermatologist to check suspicious lesions.

VAT rise

A rise in VAT under the new government could have a negative effect on independent pharmacies, experts have warned. Numark called for as much notice as possible of any change.

Third year of double digit growth at Boots

Alliance Boots sees trading profits rise above billion-pound mark

Zoe Smeaton
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Alliance Boots has seen a double digit growth in trading profit for the third consecutive year, the company announced in its preliminary results.

Trading profits exceeded the £1 billion mark for the first time in 2009-10 and were up 12.7 per cent from last year, reaching £1.07bn.

Profits in the health and beauty division also rose by 8.5 per cent. And Boots UK reported a rise in dispensing and related income of 1.7 per cent, which it attributed to "good dispensing volume growth".

Dispensing volumes increased to 212 million items last year with particular success seen in prescriptions collected from GPs on behalf of patients, Boots UK said. However, the rise had been partially offset by a lower average revenue per script as a result of lower generic reimbursement prices. Income from pharmacy services remained modest but rose by over 8 per cent, Boots UK said, with MUR numbers up 15 per cent on last year.

Revenue in the retail health category rose 5.6 per cent to almost £800 million while the international wholesale business saw a 17.2 per cent jump in trading profits. Membership of the Alphega Pharmacy virtual chain had risen by 37 per cent to more than 3,000 pharmacies across six countries, the group said.

Looking ahead, Boots UK said it intended to increase the number of doctors' surgeries operating in its stores, after five more had opened in the past year. Andy Hornby, group chief executive, said Boots could also see opportunities to acquire pharmacies "as and when prices become more realistic". He predicted that around 10 to 20 stores would be opened per year.

Executive chairman Stefano Pessina said the group's strong financial position meant it could continue to grow.

Online pharmacies criticised in BBC sting

The online pharmacies run by Boots and Lloydspharmacy have come under fire after it was claimed they were supplying weight loss drug Alli inappropriately.

The BBC's Watchdog programme, broadcast last week, showed an underage customer purchasing Alli at Boots' online store, and an anorexic customer buying the drug online at both Boots and Lloydspharmacy after lying about her BMI.

Both multiples said they had improved their online buying processes following the incidents.

The BBC investigation followed allegations after the launch of Alli last year that it was being made available to unsuitable customers from pharmacies. Following the latest claims, the RPSGB stressed the importance of high quality pharmaceutical care online, but said patients also had a responsibility to ensure they got the best outcomes from health interventions.

Boots said there would always be people willing to act inappropriately to obtain medicines, warning: "We cannot let the actions of a few individuals prevent the vast majority of customers who need and are entitled to purchase these products from accessing them." The Society agreed restricting supply from legitimate UK registered pharmacies may drive consumers to unregulated internet suppliers with no guarantee of quality. **HF**

Pharmacy vaccinations scoop prize

An innovative Isle of Wight programme in which community pharmacists test and vaccinate drug users against hepatitis has scooped a top medical award.

The Pharmacy Fix service won a silver medal in the Chief Medical Officer's Public Health Awards.

PSNC said it believed it was the first time a pharmacy service had won such an award against competition from medical services, calling it an impressive victory.

Isle of Wight PCT community pharmacy lead Kevin Noble said in the first six months 95 patients had completed their hepatitis vaccination courses compared to just one in the three months before the pharmacy service launched. **HF**

When hayfever strikes, Nasacort sticks

Nasacort's thixotropic[1], once-a-day formulation means that it stays where it's sprayed for maximum effect against hayfever symptoms – and with no strong odour or taste, patients prefer it over Beconase® and Flixonase®[2,3]. Give them Nasacort and help avoid problems whenever hayfever's around. For more information about Nasacort Allergy, and copies of training materials and point-of-sale items, please contact your local Laser Healthcare Pharmacy Business Manager or call 01202 780558.

Contains triamcinolone acetonide

Stays where it's sprayed

NASACORT ALLERGY NASAL SPRAY (TRIAMCINOLONE ACETONIDE) PRESCRIBING INFORMATION

Presentation: 20 ml bottle, providing 30 actuations containing 55mcg triamcinolone acetonide per metered dose. **Indications:** Treatment of the symptoms of seasonal allergic rhinitis. **Dosage and Administration:** *Patients aged 18 years and over:* The recommended dose is 220 micrograms as 2 sprays in each nostril once daily. Once symptoms are controlled patients can be maintained on 110 micrograms (1 spray in each nostril once daily). The minimum effective dose should be used to ensure continued control of symptoms. Medical advice should be sought if symptoms worsen or persist after 14 days treatment. **Contraindications:** Hypersensitivity to the active substance or excipients, infection in the nose. **Precautions and Warnings:** If adrenal function may be impaired, take care when transferring patients from systemic steroids. Localised infections of the nose and pharynx with Candida albicans has rarely occurred. Following recent nasal surgery or recent prolonged nose bleeds or any other nasal problems patients should consult their doctor before use. Treatment with high doses may cause adrenal suppression Not recommended under 18 years. Not to be used for longer than 3 months without consulting a doctor. **Interactions:** No interactions known. **Pregnancy and Lactation:** Should not be administered during pregnancy or lactation unless therapeutic benefits outweigh the potential risk to the foetus/baby. **Adverse Reactions:** The most commonly reported adverse reactions are rhinitis, headache and pharyngitis. *Respiratory disorders:* epistaxis, nasal irritation, dry mucous membrane, naso-sinus congestion and sneezing; rarely, nasal septal perforations. In clinical trials these adverse reactions with the exception of epistaxis, were reported at approximately the same or lower incidence as placebo treated patients. Skin or subcutaneous disorders: rarely allergic reactions including rash, urticaria, pruritus and facial oedema. Systemic effects of nasal corticosteroids may occur, particularly when prescribed at high doses for prolonged periods. **Retail Price:** 30 metered dose bottle: £4.95 **Legal Category:** P. **Marketing Authorisation Number:** PL 04425/0605. **Refer to Summary of Product Characteristics for full prescribing information. Further information is available from the Marketing Authorisation Holder:** Medical Information Department, sanofi-aventis, One Onslow Street, Guildford, GU1 4YS. Tel. 01483 505515. **Date of Revision of Prescribing Information:** April 2010.

Information about adverse event reporting can be found on www.yellowcard.gov.uk Adverse events should also be reported to the sanofi-aventis drug safety department on 01483 505515.

References: 1. Nasacort Summary of Product Characteristics, October 2008. **2.** Lumry W et al. A comparison of once-daily triamcinolone acetonide aqueous and twice-daily beclomethasone diproplonate aqueous nasal sprays in the treatment of seasonal allergic rhinitis. Allergy Asthma Proc 2003;24(3):203-10. **3.** Stokes M et al. Evaluation of patients' preferences for triamcinolone acetonide aqueous, fluticasone propionate, and mometasone furoate nasal sprays in patients with allergic rhinitis. Otolaryngol Head Neck Surg 2004; 131(3):225-231.

PIP code 342-5501.

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Because health matters

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Dispensary talk

Do commercial interests ever affect your professional judgement?

"At the end of the day there is a business to run and if you bankrupt the shop then there will be no services for anyone. Like everything else in life it is about balance and usually professionalism wins."
Kevin Western, Day Lewis, Essex

"Maybe some pharmacists are not [completely] professional, but professionalism has to override commercial judgement."
Geoff Ray, Total Health Pharmacy, Norfolk

Web verdict

They must: we're businesses 46%

Suspect they may for some 54%

No, never 0%

Another view: There's a cynical vibe this week as not one respondent thought commercial interests would never trump professionalism. But less than half were prepared to admit to putting businesses first themselves, instead pointing the finger at others in the sector.

Next week's question: Can we really solve the sector's stress problem? Vote at **www.chemistanddruggist.co.uk**

Scotland sees chronic meds service finalised

Contractors to trial service with 50 patients to help set fees

Hannah Flynn
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Scotland's chronic medication service has been finalised following lengthy negotiations between Community Pharmacy Scotland and the Scottish Government.

The service had originally been set to launch in April 2009, but a service specification, directions and implementation plan for NHS Boards have now been released by the Scottish Government.

Pharmacists will test the service on up to 50 patients this year, with remuneration and other details being confirmed at a later date.

Under the agreement, contractors will be expected to create a list of patients eligible for the service and register up to 50 patients by December. They will assess and develop patients' care plans, dispense any serial prescriptions and be responsible for any issues arising.

An independent review group will oversee this initial phase of the service.

Community Pharmacy Scotland spokesperson Alex MacKinnon, said: "The reason we are getting pharmacists to compile a list of 50 patients initially is so we can work out how long each patient will take each pharmacist to deal with.

"We are also negotiating pay for the service."

Contractor George Romanes who helped develop the proposals was pleased with the results, calling the proposals "achievable" despite other pressures on pharmacists.

"Pharmacists should now aim to see a couple of patients a week between now and December," he suggested.

Community Pharmacy Scotland has released standard operating procedures for registration, care planning and serial prescriptions for contractors to consult during the implementation phase.

To view the SOPs, go to www.communitypharmacyscotland.org.uk

In England there is no national service for pharmacists helping patient with long-term conditions, but PSNC said it was now focusing on targeted MURs and the development of a national adherence-focused service.

What do you think of the CMS roll-out plan?
hannah.flynn@ubm.com

"At last we have a Secretary of State who understands health", I suggest a thorough independent review of EPS, meanwhile suspending payments for it."

Read Uma Patel's letter to Andrew Lansley at www.chemistanddruggist.co.uk/comment

Clinical debate

In a new series, C+D's Chris Chapman looks at the evidence behind the headlines

Does overtime equal an early grave?

Last week's papers were filled with dire warnings that working extra hours is bad for your health, leading to heart attacks and an early grave. So where did the sudden panic spring from?

The source is the Whitehall-II study, which ran from 1985 to 2004 measuring the health of 10,308 civil servants working in – wait for it – Whitehall. Although not a randomised-controlled trial, it's hard to ignore due to the sheer size of population it followed, and the length of time spent doing it.

In their latest report in the European Heart Journal, the Whitehall-II authors look at a cohort of 6,014 government mandarins, followed for an average of 11.2 years.

The good news is that working an extra one or two hours didn't make much difference in terms of coronary risk. However, the authors found budding Sir Humphreys who worked three or four hours of overtime a day were at 60 per cent greater risk of coronary heart disease (CHD) than those who stuck to office hours. And this result was independent of factors such as smoking, weight and cholesterol.

The authors admit it's probably too early to make a definite link between CHD and overtime, or to identify a definite mechanism. But in 2008 the study reported a link with work stress, which increased CHD risk by 68 per cent in patients aged under 50 – so it could be those working longer hours are more stressed.

It's also possible that those who feel chained to their desk are more likely to work despite being ill – which the study found to be linked with myocardial infarction in 2005.

That said, the results should set off alarm bells for hard-pressed pharmacists. While the study talks of overtime, it actually measured hours worked. And according to Whitehall-II, civil servants work seven to eight-hour days. That means the danger could be for people working, on average, 11 to 12 hours per day – not uncommon in a busy dispensary.

There is a raft of risk factors for CHD. A case seems to be made for workload to be added to the list, but at the very least, there is a compelling argument for pharmacists to relax once in a while.

Does the evidence stack up? Join the debate: chris.chapman@ubm.com

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Royal Pharmaceutical Society

Support Recognise Develop

Workplace pressures campaign: where did it all go so wrong?

COVER STORY As C+D's Salary Survey 2010 reveals a sector still at pressure point, Zoe Smeaton asks whatever happened to the Workplace Pressure campaign and where we can go from here

In January 2009 the RPSGB promised to tackle workplace pressures by giving much needed support to both pharmacists and employers. Guidance would be issued on how to move forward, said president Steve Churton. And the new professional leadership body would help employers to resolve the factors leading to workplace pressures.

The promises were just what a sector buckling under the pressure needed to hear, but fast forward 16 months and very little has changed. The Society points to successes such as progress made on the decriminalisation of dispensing errors and it's true it has produced guidance intended to help reduce stress. But the C+D and PDA Union Salary Survey 2010 reveals that 85 per cent of pharmacists have been stressed at work in the last year. Furthermore, just 0.4 per cent of respondents felt the Society's campaign had been very successful, with almost three quarters thinking it had not been at all successful. And for many stress levels are even higher than ever. As one Salary Survey respondent puts it: "[My employer] has HR resources and an independent helpline, both of which I have used recently for the first time in more than 30 years."

So where did it all go wrong?

For some the blame lies firmly with the Society itself. Mark Koziol, chairman of the PDA Union, says he has been "bitterly disappointed" with the results of the campaign, calling it a wasted opportunity. He believes the Society should have used its regulatory powers when it had the chance, to force change in the workplace.

For example, the RPSGB Council "strongly recommended" in August 2009 that employers should ensure pharmacists took adequate rest breaks. But Mr Koziol says without the threat of disciplinary action against employers failing to follow the guidance it is not making a difference. He says the statement may have given a "warm glowing feeling" but he asks: "Was it made a requirement? Was it put into the Code of Ethics?"

Lindsey Gilpin, chair of the RPSGB's English Pharmacy Board, says workplace pressures are "a moving feast" so that as soon as one pressure has been dealt with another issue is likely to arise, so the campaign would have to be ongoing.

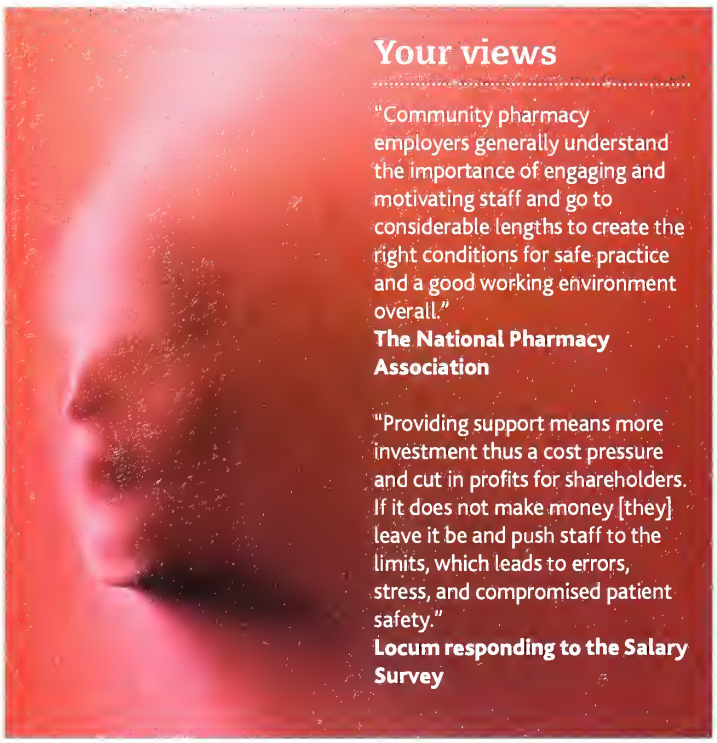
And there may be some truth in saying there are factors outside of the Society's control to blame for the rising pressures. Many respondents to the Salary Survey suggested their employers were in part to blame for expecting too much of them without offering sufficient support. In fact, 85 per cent of pharmacists say they have not received support from their employers when suffering stress and other related problems.

Employers say they are taking steps to reduce the burden, but realistically there may be only so much they can do. Part of the problem may be that there is simply more work as prescription volumes continue to grow, services expand and requirements such as information governance demand yet more time from pharmacists.

If the increasing requirements being imposed on the sector from outside really are the crux of the problem then the obvious solution is to give the sector the income it needs to deliver the services without collapsing under the strain. Certainly the NPA thinks this is the answer, as a spokesperson told C+D: "The rising volume of workload associated with new services and increased script volume must be recognised in contractual negotiations with the government." And Ms Gilpin agrees: "The short answer is that we do need a bit more money in the pot to deliver everything."

Even with a cost of service inquiry, this is hardly going to be easy to achieve. But there is some hope on the horizon, as Ms Gilpin says the Society will continue to call for measures to ease pressures on pharmacists. The NPA has also launched a drive to limit the burden of paperwork in community pharmacy. And Mr Koziol says the prospect of a new regulator, which has so far seemed willing to talk to pharmacy organisations, could offer hope that employers will be held to account.

How successful these pharmacy bodies will be in their quests to reduce pressure remains to be seen. For now all pharmacists can do is feed their concerns into them, preferably with possible solutions, and hope their representative bodies use the information to start to have some influence. If all of this happens, then perhaps 2011's Salary Survey will show some more positive results.



Your views

"Community pharmacy employers generally understand the importance of engaging and motivating staff and go to considerable lengths to create the right conditions for safe practice and a good working environment overall."
The National Pharmacy Association

"Providing support means more investment thus a cost pressure and cut in profits for shareholders. If it does not make money [they] leave it be and push staff to the limits, which leads to errors, stress, and compromised patient safety."
Locum responding to the Salary Survey

Workplace Pressure campaign timeline

January 2009: campaign launched [illegible] president Steve Churton
April 2009: RPSGB and PPRT host a two-day symposium on pressures
August 2009: Council "strongly recommended" employers ensure pharmacists take rest breaks
September 2009: Society publishes reports on professional workload and on its own symposium identifying actions to help ease pressures
February 2010: Lindsey Gilpin elected chair of English Pharmacy Board and promises dedicated email address for pharmacists to feedback on workplace pressures (lindseygilpin@hotmail.com).
March 2010: Society calls for action on stock shortages and decriminalising dispensing errors

How do we solve workplace pressures?
zoe.smeaton@ubm.com

Are you ready for the hayfever season?

PRESCRIBING INFORMATION
Fexofenadine Hydrochloride
Telfast 120mg film-coated tablets
Presentations:
The tablets are film-coated peach coloured tablets containing 120 mg fexofenadine hydrochloride, equivalent to 112 mg of fexofenadine.
Indications:
For relief of symptoms associated with seasonal allergic rhinitis.
Dosage & Administration:
For the treatment of seasonal allergic rhinitis in adults and children aged 12 years and over, the recommended dose of fexofenadine hydrochloride is 120 mg once daily before a meal. The efficacy and safety of fexofenadine hydrochloride has not been established in children under 6 years of age.

Contra-indications:
Known hypersensitivity to any of the product's ingredients.
Precautions:
Studies in adults have shown that it is not necessary to adjust the dose of fexofenadine hydrochloride in the elderly or in renally or hepatically impaired patients. However, fexofenadine should be administered with care in these special groups.
Side effects (Please refer to the Summary of Product Characteristics for full side-effect details):
In controlled clinical trials the incidence of commonly reported adverse events observed with fexofenadine was similar to that observed with placebo. These adverse events were headache, drowsiness, nausea, dizziness, and sleep disorders or paroniria, such as nightmares. In rare cases rash, hypersensitivity reactions with manifestations such as angioedema, chest tightness, dyspnoea, and systemic anaphylaxis have also been reported.
Pregnancy & Lactation:
Fexofenadine is not recommended in pregnancy or for mothers breast-feeding their babies, due to absence of experience in this group of patients.
Legal Category: POM
Marketing Authorisation Number: PL 04425/0157
NHS Price: Pack of 30 Tablets: £ 6.23
Further information is available from Winthrop Pharmaceuticals, One Onslow Street, Guildford, Surrey, GU1 4YS.

Date of Revision of Prescribing Information: April 2009

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For further information please visit our website www.winthrop-pharma.co.uk, freephone 0800 854431 or contact Winthrop Pharmaceuticals, 1 Onslow Street, Guildford, Surrey, GU1 4YS. Fax number 01483 554831. Date of Preparation April 2009. STN: 374

Disney update for Kool 'n' Soothe packs

Kobayashi Healthcare has repackaged children's cooling gel sheets Fever Kool 'n' Soothe.

The redesigned packaging will feature characters from Disney's Mickey Mouse Clubhouse, as will the cooling gel sheets themselves.

The move follows "strong sales growth" last year, Kobayashi says, and marketing investment in the Kool 'n' Soothe brand has been doubled in 2010.

A TV campaign is scheduled for July 2010.

Price: £2.65/4; £4.69/8
Pip codes: 280-7071; 299-6510
Kobayashi Healthcare
Tel: 0208 987 9976
www.kobayashihealthcare.com

Market focus

- The rising child population and "a move towards pharmacist-led medication" is expected to contribute to a £20 million growth of the UK children's OTC and healthcare products market to 2014.
- More than 26 million UK parents have bought medicine or medicated products for their children in the last 12 months.
- More than three quarters of parents buy medicine or healthcare products for their children that have been recommended to them – highlighting the importance of the roles of pharmacists and doctors.

Source: Mintel Oxygen, August 2009

Listerine backs Teeth4Life

Johnson & Johnson brand Listerine is working with the British Dental Health Foundation on a 'Teeth4Life' campaign during the current National Smile Month.

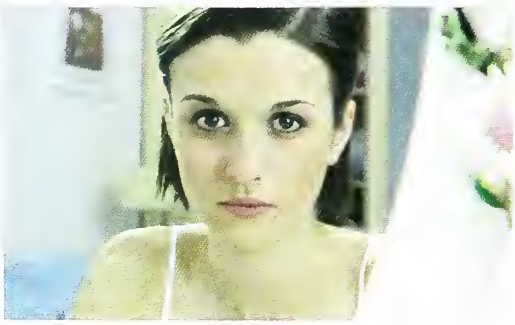
The campaign aims to encourage the public to look after their teeth and "keep them for life", according to the partnership.

New research by the partnership for the campaign has found that people in the UK are nonchalant about the state of their teeth, with six in 10 having no concerns about their dental health.

National Smile Month runs until June 16.

Prices: from £2.39
Pip codes: see C+D Monthly Price List or www.cddata.co.uk
Johnson & Johnson

Sudocrem skincare supported by television campaign



Forest Laboratories is running a television campaign for its Sudocrem Skin Care Cream.

The advertisement burst will run until the end of this month and will reach 63 per cent of Sudocrem's total audience, according to the company.

The advertisement will feature a drama student recently named "the face of Sudocrem" due to her "girl-next-door looks", Forest Laboratories says.

Sudocrem Skin Care was launched last year in a "handbag friendly" 30g tube.

Price: £1.89/30g
Pip code: 346-3098
Forest Laboratories
01322 421800

Homeopathy Awareness Week to be sponsored by Nelsons

Homeopathy manufacturer Nelsons is once again joining forces with the Society of Homeopaths to promote Homeopathy Awareness Week in June.

Nelsons is the sole sponsor of the promotional leaflet and poster campaign, and has sponsored the event for the last six years.

Homeopathy Awareness Week runs from June 14 to 21, and the theme for 2010 is women's health.

Events being held include a makeover of Nelsons Homeopathic Pharmacy in London's Mayfair to recreate a Victorian pharmacy, the company says. This year Nelson is celebrating its 150th birthday.

Nelsons
www.nelsonsnaturalworld.com

P&G launches retail help site

Procter & Gamble has launched a website for its pharmacy retail support group.

The PharmacyCare website will [illegible] retail skills training and [illegible] documents for [illegible]tion, and encourage [illegible]d pharmacy staff to [illegible]ice. It follows the [illegible]s ago of the [illegible] programme.

[illegible] shows health [illegible] pharmacies is in decline [illegible] shoppers are moving away from value brands and returning to branded products.

To combat the decline, the company launched its Competitive Value Proposition, which was introduced to stores in April.

The initiative offers displays for discounted P&G 'signpost brands' and nearly 800 stores have signed up since last month.

Ceuta Healthcare
01202 780558
www.pharmacycare-online.co.uk

alli On TV next week

Flomax Relief MR: ITV, five, Sat
Lanacane Anti Chafing Gel: All areas
Nicorette Inhalator: All areas
PharmaSite for next week:
Oilatum – windows, **Oilatum** – in-store, **Oilatum** – dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

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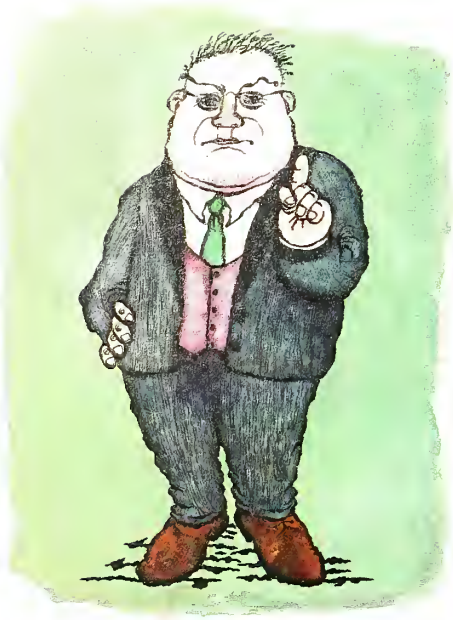
Ridiculous accusation of profiteering



"LAST WEEK I READ A BMJ ARTICLE THAT SAYS I AM PROSTITUTING MY CLINICAL SELF"

I was reminded last week of a discussion I had years ago with a friend working for a merchant bank in the City. We both had the ex-student realisation that a proper job is actually pretty boring, and spent a long time trying to decide what other skills we had to make money. After considering all possibilities from male gigolo to things more illegal, we decided the only way not to starve was to carry on as we were. But then last week I read a BMJ article that says I am prostituting my clinical self after all.

According to this article, printed in the BMJ but referred to in last week's C+D (p8), I work in the "for profit community pharmacy sector", and my public health role is diminished by that commercial aspect. The article concludes with concerns about my "effectiveness, equity, efficiency, value for money, and above all the implications for access, safety, and quality of patient care"!

What planet are these writers living on? Of course we have to make a profit – to pay wages, business tax, VAT and rates, and all those things that keep the economy going. In business we have to balance our books, which is why I haven't got billions of pounds of debt, unlike the latest claimant of Job Seeker's Allowance, Mr Brown.

And if the authors think GPs are so altruistic, they should remember that BBC quote of doctors that opting out of evening care responsibilities was "a bit of a laugh", and the NHS Confederation CEO saying "I think it is always easy to underestimate how strongly GPs respond to an incentive that gives them money". So when we see prescribing trends change from one brand to another, that's usually because the GP has accepted incentive money from the PCT to make that clinical decision.

Let's also not forget that profit brings competition, an unknown concept to our GP colleagues. Their 'customers' are allocated to them and there's little incentive to build services around patients.

In my world, the only way to survive is to provide a better service than the next place, so that my patients – who have genuine choice over their service provider – will step through my door. Our PCT is increasingly shifting services into community pharmacy because they experience better engagement, better access, and better value for money, and they recognise pharmacy as the only option when it comes to supporting the NHS agenda for self-care. No wonder surgeries are reluctant to signpost patients to us for minor ailment schemes and the like, because as our value increases they fear their value decreases.

But perhaps life is not so bad in the "for profit" sector. Our patients appreciate us, and my friend in the City now earns less than me, has less hair than me, and had his ulcer before me, so maybe I'm not so badly off.

No guarantees for pharmacy in Lib-Con NHS

It has been a cataclysmic fortnight in Westminster and a remarkable few months for British politics. We are undoubtedly in uncharted political waters. But as our politicians get back to the business of governing, we must assess what this election means for pharmacy.

However, we must pay tribute to our sector's success over the past few hectic months. To its enormous credit, community pharmacy made itself a part of this remarkable campaign in a way it has never done before. Contractors across the country came out in force, powerfully articulating to their prospective parliamentary candidates just how much their local pharmacy can deliver. Their efforts made sure our message was as clear as it could be: community pharmacy can deliver tremendous value for money for NHS organisations, and dramatic improvements for NHS patients.

However, we cannot afford to fall [illegible] election marks only the end of the beginning. With the NHS facing its harshest ever funding environment, and its leaders casting about for ways to "deliver more with less", it has never been more important to ensure our politicians understand the case for pharmacy's development.

That is not to say that our progress thus far counts for nothing. Both the parties that have now formed our new government have strongly endorsed a large-scale development of pharmacy's role.

The Conservatives' Public Health Green Paper committed to "develop pharmacists' involvement in preventive care" and "integrate these measures into the pharmacy contract". The Lib Dem shadow health secretary argued "pharmacists have a really important role to play in screening and awareness about a host of public health issues". Both Tory and Lib Dem health spokespeople expressed a will to improve pharmacists' involvement in local commissioning structures. And the Lib Dems' welcome pledge to decriminalise dispensing errors has been echoed by Tory frontbenchers.

These are all positive pledges. Contractors should be cheered. But they should not be complacent. The corridors of Whitehall and Westminster are littered with unfulfilled commitments. As Andrew Lansley told the Today programme on his first morning as health secretary, the government's pledge to raise NHS spending in real terms does not mean the NHS will be protected from serious funding pressure. Pharmacy will no doubt face its fair share of pressure to deliver more for less. If we are to effectively progress our agenda in this climate, we must keep the pressure up.

This is why PSNC is calling upon all contractors to build upon the momentum we have sustained during this campaign. Let us match the strength of our message with the vigilance of our efforts.

Sue Sharpe is chief executive of PSNC

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Update

Your weekly CPD revision guide

Pregnancy: the third trimester

Problems encountered in the third trimester range from thrush to pre-eclampsia. This article explains how they can be managed

60-second summary

Are you aware of the main hazards of the last few weeks of pregnancy? This article can be used as part of your CPD to help women cope with common ailments.

What happens to the baby at this stage?

The baby gains weight rapidly. The lungs mature in preparation for independent life, and continue to develop until the child is eight years old, which is why childhood asthma may resolve with age. The sucking reflex is established by about 36 weeks, so babies born earlier may have problems feeding.

What are common problems for the mother?

Sciatica, varicose veins, palpitations, stretch marks, dry itchy skin, feeling excessively hot and sweaty, indigestion, poor sleep, thrush and stress incontinence. Most of these resolve after the birth, but rhesus disease and pre-eclampsia are more serious.

This article (Module 1527) can help in the following CPD competencies: C1a, C1c, C1d, C1a, C1c. See http://tinyurl.com/68ox7b

Katharine Gascoigne MRPharmS

At the beginning of the third trimester the baby is already fully formed with all its vital organs in place. At 26 weeks the average foetus weighs around 760g; from that time, as fat is laid down subcutaneously, weight gain is rapid and the average weight at birth is around 3.4kg.

This final stage of pregnancy is important for lung development. By week 29 the bronchioles are mostly in place and the subsequent formation of alveoli continues throughout the rest of the pregnancy and beyond birth. The lungs are not considered to be fully mature until a child is eight years old (hence childhood problems such as asthma often resolve with age).

The foetal adrenal glands release cortisol, which stimulates the production of lipid surfactant in the foetal lungs. This coats the alveoli, reducing the internal surface tension and increasing their elasticity, enabling them to expand without collapsing when the baby takes its first breaths. If a premature birth is anticipated the mother will be given a steroid injection, which stimulates the lungs to produce surfactant. At 35 weeks gestation the lungs are considered to be mature enough for survival and the baby should not require special care if born at this stage.

The brain and nervous system are now fully formed. As the brain continues to grow, it starts to fold in on itself, causing its characteristic walnut appearance. Myelin covers all the nerves, allowing fast transmission of impulses, which leads to more intricate movements and an increased ability to learn.

The sucking reflex is only properly established at around 36 weeks and babies born before this time may have problems feeding.

The digestive system starts to function and the intestines fill with dead skin cells, shed lanugo hair and secretions from the baby's bowel, liver and gall bladder. This is meconium, which becomes the baby's first bowel movement.

Towards the end of this trimester, the baby turns so that it is head down in preparation for the birth. To enable delivery, the skull bones are not yet fused together and remain soft so they can slide over each other and change shape as they pass through the birth canal and vagina.

As the baby grows, the amount of amniotic fluid decreases so the baby becomes quite cramped within the uterus. The fluid peaks at around one litre at 35 weeks then declines to as little as 100-200ml in an overdue pregnancy. This, as well as the fact that the placenta stops functioning properly, is why pregnancies are not normally left to go beyond 42 weeks.

Changes in the mother

As birth approaches, nearly all women suffer at least one ailment associated with their pregnancy. They should be reassured that, in most cases, their problems will disappear after the baby is born. Excessive weight gain can exacerbate these problems so women should be advised to eat healthily and keep active if possible.

Blood volume peaks at around 35 weeks, with cardiac output also rising up to this point. The blood vessels reach their maximum capacity and this, accompanied by a slight increase in peripheral resistance, leads to a gradual rise in blood pressure. Palpitations are common because of the high blood volume and the fact that the mother's internal organs have been moved and compressed as the uterus has grown upwards. Increased blood flow to the skin makes pregnant women feel excessively hot and they may sweat more than usual. In palmar erythema, the palms of the hands and soles of the feet look red and feel as though they are on fire.

Varicose veins, resulting from the high blood volume combined with the weight of the uterus pressing down on to the main veins in the pelvis, may appear in the legs, vulva or anal region (haemorrhoids). Support tights, resting with legs elevated, walking and avoiding excessive weight gain can all help.

The large amounts of fluid in the body cause tissues to thicken and may make fingers, legs and feet swell. Some women suffer from carpal tunnel syndrome, which occurs when fluid retention causes swelling of the tissue in the wrist known as the carpal tunnel. The swelling presses on the nerves and ligaments resulting in numbness, tingling or weakness in the hand. It may be eased by keeping the affected arm elevated or, in severe cases, a physiotherapist may prescribe a splint to support the wrist.

Women often develop stretch marks and patches of dry itchy skin as the skin stretches over the bump. Itching may be eased by applying simple moisturisers but on rare occasions it can be a sign of obstetric cholestasis, so if it is severe and sustained the woman should seek urgent advice from her GP or midwife.

The breasts continue to grow and absorbent breast pads may be needed as some women start to leak small amounts of the first milk, known as colostrum.

An increase in vaginal discharge is normal

A blood test at 28 weeks checks for rhesus type and anaemia

...pregnancy and at this stage it may become ...d with blood as the cervix softens in ...ration for childbirth. If the discharge appears ...rmal in any other way, infection must be ...ted out because it increases the risk of premature labour if untreated. Thrush commonly occurs during pregnancy as hormones create a less acidic environment that encourages the growth of candida. It may be treated with clotrimazole cream and pessaries, as fluconazole is contraindicated.

Some women may develop stress incontinence, which can be helped by doing regular pelvic floor exercises. These should be continued after birth to maintain a strong pelvic floor and reduce the risk of developing incontinence later in life.

Heartburn, indigestion and decreased appetite are common complaints caused by compression and displacement of the stomach and intestines as the uterus grows. This also causes breathlessness as the diaphragm is pushed upwards against the lungs. These symptoms are often accompanied by rib pain as the rib cage extends outwards. Sitting may make these problems worse, so sufferers should be advised to move around and retain good posture. Towards the end of pregnancy the baby's head will usually descend into the pelvis and become engaged. This is often referred to as 'lightening' and results in an easing of these symptoms.

Backache is common throughout pregnancy but in the latter stages more specific problems may develop. Sciatica can occur as a result of the baby's head pressing on the sciatic nerve causing pain, numbness and tingling. Gentle exercise and manoeuvres to encourage movement of the baby may help. Coccygeal pain may be experienced as loosened ligaments result in the coccyx becoming displaced. This can be eased by applying heat to the area.

Sacro-iliac pain in the middle or lower back is again a result of relaxed ligaments combined with increasing weight causing the sacro-iliac joints to become unstable. It can be extremely painful and may need physiotherapy.

Pubic symphysis dysfunction occurs when ligaments loosen so much that the two pubic bones rub together while walking or moving the knees apart. Ice packs may help as will paracetamol-based painkillers, with severe cases needing crutches.

Braxton Hicks' contractions are painless practice contractions of the uterus that start at this stage of pregnancy. Many women do not notice them but for some they can feel quite strong and uncomfortable. Moving position, a warm bath and the use of relaxation techniques may help. If the contractions are sustained and quite painful, the woman should be aware that this might be the beginning of actual labour.

One of the most common complaints from women at this stage is that they are unable to sleep, mainly because they are now so large that it is difficult to find a comfortable sleeping ...sition. Extra pillows under the head, between ...legs or underneath the bump may help. ...ng flat on the back should be avoided if ... as the weight of the uterus pressing down ... major veins could reduce blood supply ... ... disturbed by regular trips to the toilet, leg cramps, disturbing or vivid dreams and anxiety about the impending birth. Urinary infection should be ruled out if the woman is frequently passing very small amounts of urine or if there is any discomfort or bleeding.

Antenatal care

Antenatal appointments become more frequent in the weeks leading up to the birth. As before, the woman's urine is checked for glucose and protein and her blood pressure is measured. A blood test is performed at 28 weeks to check rhesus type and for anaemia. If the haemoglobin level is below 11g/dl, iron supplements are usually prescribed and the woman should be counselled about possible gastrointestinal side effects. At this stage the birth plan is discussed and, assuming all goes well, a natural birth occurs at around 40 weeks gestation.

Rhesus disease

When a rhesus negative mother gives birth to a rhesus positive baby the mother may produce antibodies against the baby if some of the baby's blood enters the mother's bloodstream. This means that if the mother were to become pregnant again with an Rh-positive baby, she may produce antibodies that cross the placenta. This can cause haemolytic disease, which can lead to anaemia and jaundice in the newborn.

If an Rh-negative woman has not been sensitised to Rh-positive blood, an injection of anti-D immunoglobulin can prevent this sensitisation. The injection neutralises any foetal Rh-positive antigens that have entered the mother's blood and prevents the formation of antibodies. The routine administration of anti-D is offered to Rh-negative women at 28 and 34 weeks and after birth.

Pre-eclampsia

Pre-eclampsia is a condition of pregnancy where high blood pressure is accompanied by oedema and proteinuria. It is most common in first-time mothers, multiple pregnancies, diabetic pregnancies and women with pre-existing hypertension or kidney disease.

Pre-eclampsia mostly presents in the second half of pregnancy, although it may develop any time before or even after delivery of the baby. The mother is often symptom-free but some may experience excessive swelling of the face, hands or legs or have severe headaches. If mild it can be treated with oral antihypertensives, commonly methyldopa or nifedipine.

In moderate pre-eclampsia (BP over 140/100mmHg accompanied by proteinuria and marked oedema) the mother should be hospitalised to bring the blood pressure under control and monitor the baby. In severe cases the blood pressure exceeds 160/110 and there is heavy proteinuria and oedema. There is a risk of the mother having a seizure, premature delivery, placental abruption or intra-uterine death. Immediate IV antihypertensives (hydralazine or labetalol) and sedatives are indicated, together with delivery of the baby by caesarean section. Magnesium sulphate is used to prevent recurrent seizures in eclampsia and to delay women with pre-eclampsia developing eclampsia.

References

Regan, L (2005) Your pregnancy week by week. London: Dorling Kindersley.
Babycentre (2010) www.babycentre.co.uk
NHS Choices (2010) www.nhs.uk/planners/pregnancycareplanner

Katherine Gascoigne, MRPharmS, is a part-time locum and writer

Download a CPD log sheet that helps you complete your CPD entry when you successfully complete the 5 Minute Test for this Update article online (p20).

NEXT WEEK
Two MUR case studies look at the problems of a diabetic woman and a heart failure patient

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* Source: Neilsen: Total Chemists MAT Value & Unit Sales (11.12.09)

the final weeks

When are the lungs considered to be fully mature? What is palmar erythema? Why is thrush common in pregnancy? What are the symptoms of pre-eclampsia?

This article describes the changes that occur in mother and baby in the third trimester of pregnancy. Common problems and complications are discussed, including rhesus disease and pre-eclampsia.

- Read the information for weeks 31-42 on the Stages of Pregnancy website at http://tinyurl.com/y6jya64.
- Find out more about palmar erythema from the Patient UK website at http://tinyurl.com/y7rjwst and obstetric cholestasis from the OC Support UK website at http://tinyurl.com/yyfznyk.
- Update your knowledge of pre-eclampsia from the Patient UK website at http://tinyurl.com/y2omp7u and rhesus disease from the CKS website at http://tinyurl.com/y4tgot8.
- Think about the products you would recommend for skin problems, pain relief and indigestion, and make sure your counter assistants are aware of your choices.
- Think how you could encourage expectant mums to visit your pharmacy. Talk to the local midwife or offer to speak at local antenatal classes.

Are you now familiar with the changes that occur to mother and baby during the final weeks of pregnancy? Could you advise about problems and complications?

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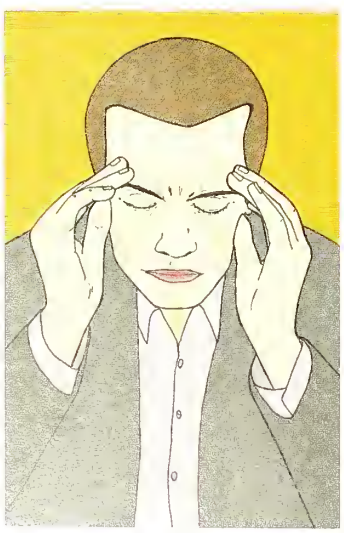
Practical Approach

Resolving headache from medication overuse



David Spencer, pharmacist at the Update Pharmacy, receives an 'early warning system' phone call from a neighbouring pharmacy that a man is going round the local pharmacies trying to buy an OTC brand of co-[illegible] tablets.

"[illegible] letting me know," [illegible] requests for OTC [illegible] containing opioids must be referred, so if he comes here I'll have a word with him."

A few minutes later the man arrives at Update and asks for the product. He is referred to David, who takes him to the consultation area.

"I hear you're going round the area asking for these," David says. "Is there any way I can help you, besides just selling them to you?"

The man looks embarrassed and guilty and turns to leave, but then turns back and says: "You're the first person who's said anything like that to me. All the other chemists just say they haven't got any. I think I do need help."

David asks the man to tell him more. The man explains: "I've been taking these for migraine for a couple of years now. They worked fine at first, but then I found I needed to take them more and more often to try to keep the headaches at bay. I'm now taking them just about every day, but the headaches keep coming back. I really don't know what to do."

"Have you seen your doctor about it?" David asks.

"No, I'm too ashamed to let him know I've become a drug addict. Could you help me?"

Questions

1. What are the features of medication overuse headache (MOH)?
2. Which drugs can cause MOH?
3. How is MOH treated?
4. Can treatment be undertaken by a pharmacist?

Answers

1. Headache that is present on 15 or more days of the month and has developed or worsened while the patient has been regularly using analgesic or anti-migraine medicines for more than three months. It occurs only in patients with a pre-existing primary headache disorder, usually migraine or tension-type headache.

2. All medicines used for the treatment of headache, including simple analgesics (aspirin, paracetamol, NSAIDs), opioids, triptans and ergots, alone or in combination with caffeine, barbiturates or benzodiazepines.

3. Abrupt withdrawal of the overused medication, with no substitution of alternative medication, is the treatment of choice for most patients. Headaches or migraine attacks should gradually revert to a 'normal' pattern, usually in seven to 10 days but in some patients it may take up to 12 weeks. Patients may require drug treatment to alleviate withdrawal symptoms, including nausea, anxiety and insomnia. If patients are unable to tolerate withdrawal headache, an analgesic of a different class from the overused medication should be used short-term.

4. Possibly, but withdrawal with medical support is preferable if the patient will accept it. Patients taking opioids, benzodiazepines or barbiturates, or who are poorly motivated, pregnant or have a significant co-existing medical or psychiatric disorder, may need specialist treatment.

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The new weapon in medicines pricing

More value-based pricing is coming our way says **Gavin Atkin**. But what will it mean for pharmacies and pharma?

These are pessimistic times in pharmaceuticals: the era of big launches is largely behind us, the screw of regulation keeps tightening, and some say the pharmaceutical industry's previously successful business model is close to broken.

For many observers associated with the industry, what's called value-based pricing (VBP) could be the last straw. VBP is the notion that the price paid for treatments should be based on their benefits for patients, carers and society: it sounds innocent, but industry worries it could provide governments with an opportunity to use health economics to screw down pharma revenues in a way that could strangle drug development.

For the industry, it springs from the same well as other government measures to control costs, including Nice, which they say has unintended consequences for the way the market functions. The argument goes that if Nice recommends product X for a particular condition, there will probably be no demand for the similar product Y – and that may mean it won't be launched and there will be no competition. More, it could prevent drugmakers with a new product from following the usual development route starting with a first licence for a straightforward and easily justified indication, followed by a series of extensions that take it into new and not always related disease areas.

To the business lobby, therefore, increased centralised decision-making could easily limit business opportunities while a more open, less heavily regulated market provides the conditions for vigorous development.

A political issue

As [illegible] happens, the parties in the argument [illegible] their definitions.

[illegible] best understood definition of VBP [illegible] Office of Fair Trading (OFT) report[1] [illegible] wholesale changes to the [illegible] Price Regulation Scheme (PPRS).

[illegible] central idea of this 2005 document was that the PPRS system, which fixes pharma profit levels, should be replaced by a new scheme in which the price paid for drugs would be set in advance, and would reflect their value in terms of patient benefits.

Given the number of treatments involved, it would clearly require an enormous number of assessments and a heavyweight bureaucracy to administer it. Perhaps this was the reason the revised PPRS scheme announced in 2008 effectively rejected the OFT's proposals.

But in practice various elements of VBP are already with us, as University of York health economist professor Mark Sculpher observes.

> **"The OFT's version of VBP may be unlikely, but the PPRS has introduced patient access schemes where there is scope for price to be reconsidered if a drug turns out to be more valuable"**
>
> PROFESSOR MARK SCULPHER
> UNIVERSITY OF YORK

"The version of VBP the OFT envisaged may be unlikely in the near future," says professor Sculpher, "but the government's revisions to the PPRS in 2008 introduced things like patient access schemes where there is scope for the price to be reconsidered if a drug turns out to be more valuable than was originally thought – and so in a sense we already have value-based pricing.

"A company first decides the price it wants to charge, and Nice decides whether the NHS should pay it or not. If the manufacturers don't show value using the Nice cost effectiveness threshold, then they don't get recommended for the NHS. The options they then have are to either reduce their list price or to negotiate a patient access scheme."

These patient access deals come in numerous forms and are growing in number, says professor Sculpher – but for him the key

Drug pricing and the NHS

Drug pricing has been a point of tension from the beginning of the health service. Back then, the idea was that the fledgling NHS could be partly paid for by developing and exporting healthcare technologies such as antibiotics.

The approach that would deliver the required development was the Voluntary Price Regulation Scheme. Launched in 1956, this arrangement gave pharmaceutical manufacturers a guaranteed level of profit and was designed to encourage the R&D the country needed to pay the NHS's bills.

Later the regime was tightened and renamed the Pharmaceutical Price Regulation Scheme (PPRS), with a ceiling placed on pharma's return on capital employed – but still the principle that the scheme should promote the UK-based pharmaceutical industry remained very much in place.

No one likes to be tightly regulated, but during pharma's heyday the PPRS achieved its aim of encouraging investment in the UK. Some critics have even criticised pharma's UK investment as excessive – yet NHS spending on medicines has been relatively low compared with other Organisation for Economic Co-operation and Development countries.

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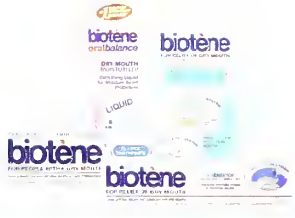
Time to talk about dry mouth?



Approximately 20% of people suffer symptoms of dry mouth[1], primarily related to disease and medication use. More than 400 medicines are associated with dry mouth[2], especially if three or more are used together[3].

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1. Billings RJ. Studies on the prevalence of xerostomia. Preliminary results. Caries Res. 23 Abstract 124, 35th ORCA Congress 1989. 2. Eveson JW. 'Xerostomia'. Periodontology 2000. 48. 85-91. 3. Sreebny LM, Schwartz SS. 'A reference guide to drugs and dry mouth – 2nd edition'. Gerodontology 1997. 14. 1. 33-47.

thing about them is that there's now more of a dialogue between manufacturers and the Department of Health through Nice about what the price of a product might be to secure cost effectiveness.

Rivals in price control

In effect, what we have in the market for pharmaceuticals is two parallel price-setting mechanisms: in the blue corner stands the PPRS; and in the red is Nice, with its recommendations, guidelines and individual patient access deals. It will be fascinating to see how the game between them plays out. Can they coexist, will they be merged or will one grow while the other withers?

Given last week's formation of a coalition government led by the Conservatives, it's interesting that support for the VBP cause comes from both right and left in politics. The VBP elements now in place were introduced under Labour, but they also have broad approval from the right, as a recent report published by the centre-right think-tank 2020health shows.

Perhaps surprisingly for an industry-sponsored document, the 2020health report accepted that many stakeholders were broadly in favour of VBP but warned against abandoning elements of the PPRS agreement that tend to encourage pharmaceutical research and development (R&D).[2] It also included two of industry's themes: that a variety of factors not currently included in health technology assessments should be part of future assessments and that the QALY (quality-adjusted life year) value threshold of £20,000-£30,000 may need to be raised for areas of high unmet clinical need.

Qualified support for VBP also comes from the Bow Group, a long-established centre-right think-tank close to the Conservative Party.

Bow Group health policy committee chairman Stuart Carroll argues that VBP is philosophically desirable – as he says, it is difficult to argue against the notion of a product being reimbursed according to its value.

However, he argues, the whole debate has become clouded in confusion and there is an urgent need for clarity about what VBP means, how it can be defined and measured. Without clear understanding, the current policy-making by the new government will lack focus and direction.

"We should be about how you price and reimburse a product in accordance with its value. VBP can be made practical, but this requires a number of clear conditions and a lucid operational framework. Moreover, it requires very clear answers to the above two questions."

From this perspective, Mr Carroll also sees potential for difficulties in the detail. "The devil is always in the detail and, to a certain degree, there will always be some amount of uncertainty until any new system is ironed out," he says. "Doing things in an incremental fashion therefore offers potential benefits. Moreover, for any move to VBP to be worthwhile there has to be a cohesive system of incentives driven by a competitive and positive industrial and economic policy that fosters and cultivates research and development, and the idea of pharma companies basing their operations in the UK.

"The idea that there is some sort of hidden secret that can take you to a perfect world is pie in the sky. The key with this whole debate is pragmatic thinking and understanding in detail the implications of reform. The key is to ensure a joined-up approach to policy formulation across government departments. My biggest frustration with the VBP debate is the lack of emphasis and focus placed on UK plc's industrial and economic policy towards pharma: the VBP debate needs to be placed in a broader context asking the searching but critical question of, 'What is the UK's strategy?'. Far too often, there does not seem to be any integrated thinking."

References:
1. OFT (2005) Pharmaceutical Price Regulation Scheme www.oft.gov.uk/advice_and_resources/resource_base/market-studies/completed/pprs
2. 2020health (2010) Implementing value based pricing for pharmaceuticals in the UK www.2020health.org

Pharmacy's man in the VBP debate

How could more VBP measures affect pharmacies? NHS Lambeth professional executive committee chair and community pharmacist Ash Soni probably knows the answer to this question better than anyone in pharmacy, after studying the issue and contributing to the 2020health report.

"With value-based pricing, the devil is in the detail," he says. "The government may not have implemented VBP as the OFT suggested, but it has brought in bits and pieces, including generic substitution, which I think reveals the potential complications of interfering with markets. It seems quite simple but it could have unpredictable impacts: it could reduce the value of the average item, but on the other hand it could be that prices will fall, and in any case drug costs borne by pharmacies might not necessarily be reduced because of the way pharmaceutical pricing works."

In the end, VBP should be about getting the best value from medicines – it doesn't mean just taking things away, says Mr Soni, who argues that the value-based option is often to prescribe more. "If you prescribe more, you'll have fewer patients having acute episodes and ending up in hospital, so therefore the value-based option is to prescribe more. If we can prevent an acute asthma attack using a drug, then we should prescribe more of it, not least because its cost is less than the cost of an admission." No doubt it's also less than the cost of time off work and the consequences of serious illness.

Mr Soni adds: "The dangerous thing to do is to say if a drug is more expensive than product X it will not be considered, or if a drug is more specialist it won't be considered, or if it is a copy. I'm absolutely keen to maintain successful competition in pharmaceuticals – that's the main point – and it's easy to create a situation where that breaks down."

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on value-based pricing

REFLECT	How is pharmaceutical pricing likely to be affected by VBP?
PLAN	Find out about the topic and follow developments
ACT	Read the recommendations for VBP published by the OFT and 2020health
EVALUATE	Consider how VBP could affect pharmacy finances and how you might prepare for them

To find out more call 0800 731 0370
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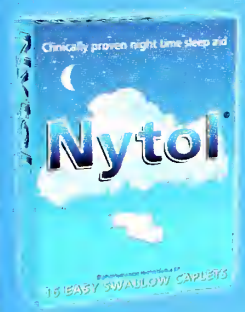

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Salary Survey 2010

Salary Survey 2010

C+D reveals how your experience of workplace pressures compares with that of your peers

Over 2,000 C+D readers contributed to the C+D and PDA Union Salary Survey 2010, including pharmacists, contractors, and pharmacy staff. In particular, hundreds of both employed and self-employed pharmacists completed the survey, allowing us to compare your experiences of workplace pressures and how you feel about them with colleagues of the opposite sex, in other parts of the country and working for different types of contractors.

Thank you to everyone who took the time to contribute – if you have any suggestions for how we can improve it next year, please email jennifer.richardson@ubm.com

The paperwork postcode lottery

When choosing where to work and live there are some things you'd expect to have to consider, but work administration volumes probably wouldn't be top of that list. Yet different parts of the UK do seem to produce varying paperwork volumes.

Overall, 88 per cent of employed pharmacists reported an increase in paperwork over the last year. But travel to London and the average was higher, with more than 92 per cent saying admin had increased – 67 per cent describing the rise as "a lot". In Northern Ireland all pharmacists responding to the survey said things had got worse and Scotland was also above the overall average.

For a relatively easy time, the best place to head is north east England, where almost a quarter of employed pharmacists say they got away without more paperwork last year, and only 37 per cent reported it had increased a lot.

Percentage of pharmacists reporting an increase in paperwork

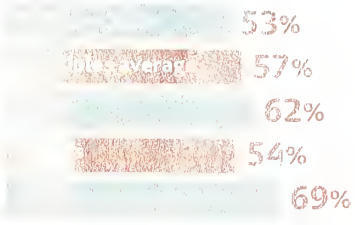
- Scotland **90%**
- Northern Ireland **100%**
- North East England **76%**
- North West England **90%**
- Midlands **89%**
- Wales **85%**
- London **92%**
- South East England **90%**
- South West England **85%**

Piles of paperwork – and RP on top

Most pharmacists have always known there are pros and cons to every employer, with all offering a slightly different mix of good and bad. This was evident when it came to administration, with independent pharmacies less likely to increase the paperwork burden on their pharmacists but also apparently slightly less able to offer enough support with the responsible pharmacist regulations. The big three multiples had their own stories, too, with the Co-operative Pharmacy accused of asking more than 95 per cent its pharmacists to do more paperwork, yet also praised for its responsible pharmacist (RP) support – 69 per cent gave it the thumbs up, making it the most popular of the three on that front. There was little to choose between Boots and Lloydspharmacy on paperwork, but Boots just won the RP battle, with 62 per cent of employees approving of its support.

Percentage who have seen a paperwork increase

Percentage who received sufficient support with RP regulations



What you said

Boots employees

"They probably did their best, but there is still a lot to clarify."

"The company I work for is great with regards to keeping on top of all the new rules and regulations."

Lloydspharmacy employees

"They ignored any difficult questions."

"I must say, Lloydspharmacy has been very helpful in this respect."

The Co-operative Pharmacy employees

"All we received from the company was a list of extra things to do."

"Excellent support which is ongoing, not just for the implementation."

The big three on red tape and RP

"Supporting our pharmacy teams in understanding and complying with regulatory change is of paramount importance to us. Ahead of the RP regulations being introduced, we developed and implemented tailored training and guidance."
Spokesperson, Boots

"I agree we have seen an increase in paperwork over the past 12 months. Along with the introduction of new professional regulations, administrative demands from PCOs have also increased. Where we can, we try very hard to limit the impact on our pharmacists by taking on administration at the centre. We put significant measures in place to support our pharmacists and their teams in getting to grips with the RP regulations, so I am both surprised and disappointed with the results of the survey."
Steve Howard, director of professional standards and superintendent pharmacist, Lloydspharmacy

"We have invested in technology to improve efficiency and worked hard to consolidate our processes and paperwork. In addition to consulting individuals at a regional level to compile the RP guidelines, we made a conscious decision to bear in mind locum pharmacists' needs."
Janice Perkins, superintendent pharmacist, The Co-operative Pharmacy

Pressure point

Pharmacists in Scotland were the most likely to report stress and depression

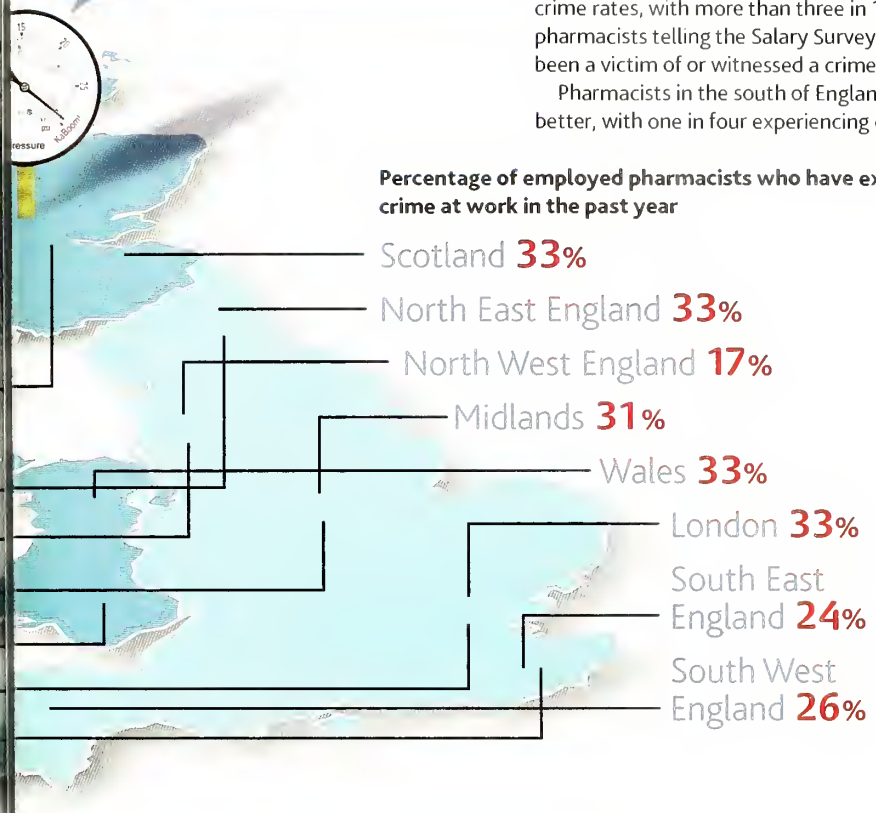
Crime hotspots

London, Scotland, Wales and the north east of England have proved the crime hotspots of the UK, with one in three employed pharmacists in these areas experiencing crime at work.

Pharmacists in the Midlands also saw high crime rates, with more than three in 10 employed pharmacists telling the Salary Survey they had been a victim of or witnessed a crime at work.

Pharmacists in the south of England fared better, with one in four experiencing crime at work, while the north west proved the safest place to practise, with fewer than one in five pharmacists witnessing criminal activity.

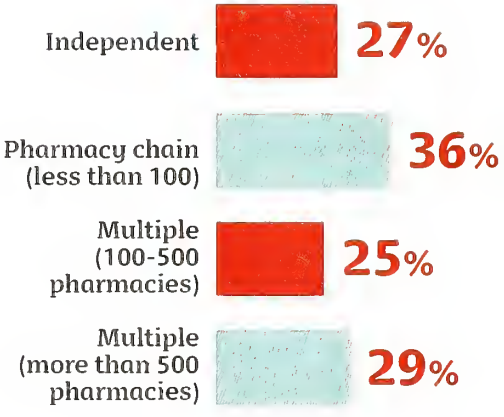
And it was bad news for pharmacists working in small chains, who were more likely to be targeted by criminals than those working in other premises. More than a third of pharmacists working in chains of less than 100 pharmacies had been a victim or witness to crime, compared with around a quarter in large multiples and independent pharmacists.



Percentage of employed pharmacists who have experienced crime at work in the past year

- Scotland 33%
- North East England 33%
- North West England 17%
- Midlands 31%
- Wales 33%
- London 33%
- South East England 24%
- South West England 26%

PERCENTAGE OF EMPLOYED PHARMACISTS WHO HAVE EXPERIENCED CRIME AT WORK



Men are from Mars...

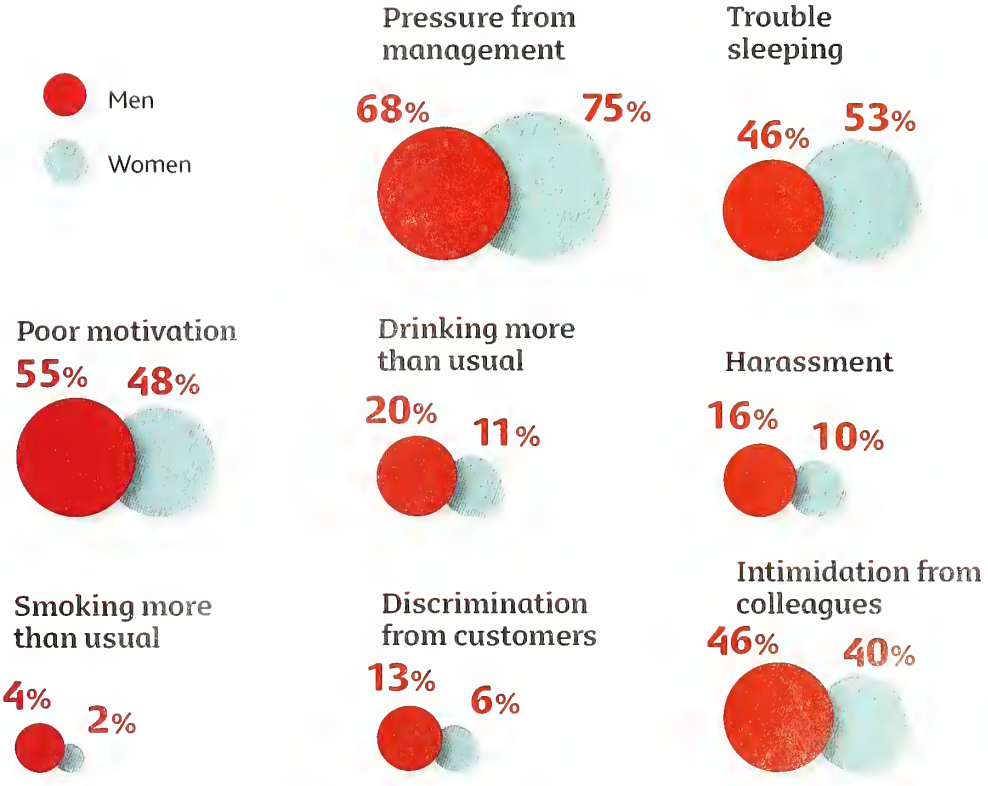
The Salary Survey suggests men and women experience, or interpret, workplace pressures differently. Similar proportions of male and female employee pharmacists reported stress and depression. But for women, pressure at work was more likely to come from management, and manifest itself in trouble sleeping. Conversely, a higher proportion of men than women reported intimidation and discrimination from customers, and harassment – and pressure was more likely to result in poor motivation. Men were also more likely to report turning to alcohol and cigarettes under pressure.

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on work pressure

REFLECT	Do I cope well with workplace pressures?
PLAN	Consider how new work processes or talking to my employer can help
ACT	Talk to employer and put processes in place
EVALUATE	Can I cope better with work pressures?

HOW MALE AND FEMALE EMPLOYEE PHARMACISTS EXPERIENCE WORKPLACE PRESSURE



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What's it like to relocate?

Pharmacist Chris Maguire left his home in Northern Ireland to relocate to a job with Lloysdpharmacy in Flint, North Wales.

I did my pre-registration training in Northern Ireland, where I grew up. There are 140 pharmacy graduates a year but only 550 pharmacies in the country. So you are basically waiting for someone to retire or move on.

I wanted to get into a big company where I could start moving up. I sent my CV to Lloydspharmacy, saying I was interested in working in Liverpool or North Wales.

The company offered me a stint as a relief manager in North Wales, followed by an internship at a store nearby. I decided to take up the post and now commute from Liverpool.

I was offered a relocation package including practical help with getting an apartment and my registration in Great Britain. Lloydspharmacy arranged for another pharmacist to train me up for a week, as the computer systems are slightly different to Northern Ireland.

There have been challenges. It was only me and my mum at home so that was difficult – but I can always visit and there are lots of Irish people in Liverpool so I don't feel far from home. Commuting to work was also a consideration, but I actually enjoy having a drive in the morning.

It has been fantastic to manage a branch so soon into my career – and a massive learning curve. I am hoping to become a cluster manager in the near future. I would not have had that opportunity without relocating. It really is the way to progress rather than wasting five years of training.

Got a burning careers question?
Email jennifer.richardson@ubm.com and we'll ask the experts

CPD: Reflect • Plan • Act • Evaluate

Log your CPD entry on my career development

- Could relocation help me to progress my career?
- Consider how I would like my career to have progressed in five years and whether a relocation could help achieve this
- Plan the individual steps needed to achieve this progression
- Do I know how I am going to achieve my career goals over the next five years?

CAREERS

Relocation, relocation

Moving can be daunting but help is available and it may open up new opportunities, finds **Victoria Hoban**

Pam MacPherson: reluctantly relocated last year, but now would recommend it

Pondering that next career move can be both exciting and daunting. But what if it also involves moving to another part of the UK – or even further afield?

Because pharmacists are needed both across the UK and worldwide, it is likely that at some point in your career an opportunity will arise that forces you to consider relocating.

"It might be a lifestyle change – a desire to move from a city to the country to bring up your kids or prepare for retirement," says Barbara Sutherland, head of capability at Lloydspharmacy. "Or you relocate to be nearer your family or partner."

Career progression is another common motivator. Your employer, or a company you want to work for, may have better opportunities. "In some parts of the UK there is a saturation of pharmacists, which can limit new opportunities, particularly for graduates," says Ms Sutherland. "Other parts of the country may be crying out for more pharmacists."

Alternatively, it may be your employer that initiates the move. "If someone had real potential in another area or for a management role at a larger flagship store we might suggest relocation as part of their succession plan," says Helen Godwin, UK pharmacy recruitment manager for Boots.

If it is you rather than your company initiating the move, it pays to be proactive. "Sometimes employees don't feel that they can ask – your employer will probably be glad to help. Speak to your line manager but don't leave it at that. Contact the HR department and recruitment team," says Ms Godwin.

Ms Sutherland, who moved from Northern Ireland to take up a job in the Lloydspharmacy head office in Coventry, says: "It's the best thing I've ever done in my career."

However, relocation can involve a waiting game so it is worth making your intentions clear early. "I told my area manager I was looking for something new," says Ricky Loughridge, a pharmacist at Asda's branch in Roehampton Vale, London. "After about a year and a half I heard about a new store opening in Sutton in Surrey. I contacted the area and store managers straight away, got an interview and was given the job and will start there in June.

"I've never started up a pharmacy from scratch – I'm looking forward to the challenge. It will also be great to put on my CV."

There will always be compromises in relocating, but often these are worth the gains. "There will be a small increase in my salary but I will be working extra hours. That did put me off a bit, but if you don't try, you'll never know," says Mr Loughridge, who previously relocated from Glasgow to London.

Although Mr Loughridge secured a relocation to his area of choice, this is not always possible, warns Ms Godwin. Areas such as the West Country and East Anglia have skills shortages, while major cities often have few posts available. "Someone moving from the south west to Manchester could struggle to find something. But it helps on both sides if we can have as much notice as possible," she says.

But what if the request to relocate comes from the employer? Are you obliged to make the move? Not according to Ms Sutherland. "We will offer financial assistance with relocation expenses, such as accommodation, as well as moral support. We encourage people by paying for flights so they can stay for a few days in the new area to get a feel for the place."

Despite the incentives, there is still a lot to consider. Different areas of the UK can have different patient services and accreditation processes, so you may need to re-accredit yourself or upskill.

If a local relocation is enforced, it can be unsettling, as Pam MacPherson, pharmacy manager at Rowlands' Kingston Crescent Surgery branch in Portsmouth, discovered when the store was relocated to new premises last year. "We had no choice in the matter – we were all quite torn, attached to both the building and the local surgery," she says.

But she admits that the new premises, with a GP surgery onsite and state of the art facilities, has had benefits for patients and staff. "The services we can offer now means we have been shortlisted to be one of six 'healthy living' pharmacies that Rowlands will be piloting in June. My role has also changed – it is now mainly managerial," she says.

"To others facing a relocation I would say go for it – change can be scary but it brings new opportunities."

COURSES

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Springboard

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in partnership with C+D Training

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The **Springboard** pre-registration training programme consists of eight study days facilitated and delivered by staff from C+D and Medway School of Pharmacy covering a wide variety of topics, enabling students to meet the appropriate competencies in the RPSGB's student handbook.

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Postscript...

Midlands fitness is child's play

West Midlands pharmacists did their bit to boost healthy lifestyles last month, when they volunteered at a sports day for local kids.

Staff from Midcounties Co-operative pharmacy joined top-class heptathlete Louise Hazel at Tipton Sports Academy's 'Fit for Fun' event to help get pupils from Wallbrook School interested in sports. The team organised a game of rounders and an educational obstacle course for the kids to tackle, including a bleep test.

Pharmacy technician Louise Scarisbrick (pictured on the floor) said the day had been amazing, with the children throwing themselves into the activities.

Are you planning anything for charity? Let Postscript know what you're up to, and we'll give you a plug. Send your pictures and stories to postscript@chemistanddruggist.co.uk.

A social tweet

From kiwis to confidentiality, join the debate at www.twitter.com/chemistdruggist

@GaryParagpuri: Afternoon off – heading up to see Flight of the Conchords in Birmingham. Anyone else a fan of the NZ folk duo?

@CandDZoe: Those in the know suggest working on information governance requirements gradually over the next year. Anyone started thinking about it?

C+D reader of the week

Meet footie fan Michael Maguire of Marton Pharmacy in Middlesbrough. Just don't put him on a rollercoaster...

What's the most annoying thing about pharmacy? The lack of knowledge of pharmacy by commissioners. And that goes right up to the Department of Health.

What did you have for breakfast? Cornflakes. It's pretty much what I always have.

What was your favourite toy growing up? My [illegible] Teddy. When I was a bit older I had a [illegible] that was quality, it felt like being a [illegible]

Where will pharmacy be in five years? [illegible] be catching up where we are now! [illegible] to check. Hopefully everyone [illegible] more services for their [illegible]

Should pharmacists wear a uniform? Not particularly. As long as they look professional.

What's the scariest thing you've ever done? Probably one of the rides at Disneyland in America. I'm a big wuss – the teapots are big enough for me!

What's the strangest request you've ever had? Probably these interviews for C+D!

What should we ask the next interviewee? If you were not a pharmacist, what would you be?

Calling all pharmacists and technicians. We want you to be our reader of the week. Email us at postscript@chemistanddruggist.co.uk

@The web hunter

For a few years after the dot-com bubble burst, it looked like it was going to be impossible to make money online. But with the advent of broadband came a plucky group of online retailers (eBay, Amazon etc) that re-wrote the book and put many high street stalwarts out of business.

The secret of Amazon's success is top-notch service. You log on to Amazon, and it shows you what you might be interested in. If you choose to purchase, it takes one click and delivery can often be the following day.

It is this level of service that C+D strives for online. We don't have the £1 billion business that Amazon has, but we try to offer what you, our readers, want in the way you want it. It was this idea that led to our recent change in email format and delivery, for instance. And we will continue to evolve and develop to meet your needs.

But what of pharmacy and its role in primary healthcare? Well this week Alliance Boots' pre-tax profits topped £1bn, so the sector must be doing something right. And Lloydspharmacy's experiment with a mole clinic is another example of increasing good service in primary care from professionals often perceived as a poor relation to GPs.

But GPs and GP surgeries suffer from the same hubris as the now defunct high street retailers. They do not always offer their customers (patients) the level of service they expect from the retail, or any other service, sector.

Take my recent experience. My 18-month-old daughter bashed her head at nursery. About 12 hours later she was sick. Following medical advice we tried to consult our GP. And despite using the phrases "small child", "head injury" and "vomiting", we were refused an emergency appointment.

My daughter was fine (thanks to A&E), but if traditional GP surgeries expect to compete with Darzi centres, polyclinics or perhaps GPs in Boots, they must put good service at the heart of what they do.

Niall Hunt is C+D's digital content editor; email him at niall.hunt@ubm.com

Last week's top stories on C+D's website

1. Exclusive: C+D and PDA Salary Survey results
2. Exclusive: Pharmacists lack pay satisfaction
3. Update 1525: How diet affects cancer risk
4. Practical approach: Can you dispense this?
5. There's more to life than pay

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